

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/30/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/16/2011
NAME OF PROVIDER OR SUPPLIER OWSLEY COUNTY HEALTH CARE CENTER			STREET ADDRESS OF PROVIDER OR SUPPLIER HIGHLAND BLVD BOONEVILLE, KY 41314 <i>Division of Health Care Southern Enforcement Branch</i>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS An abbreviated standard survey (KY15946) was conducted on March 16, 2011. The allegation was substantiated. Deficient practice was identified with the highest scope and severity at 'D' level.	F 000	Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements.		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	<u>F 157 D NOTIFY OF CHANGES (INJURY/DECLINE/ROOM)</u> <i>Residents Found To Have Been Affected</i> Resident #1 is no longer a resident. <i>Identification of Other Residents with the Potential to Be Affected</i> The Change of Condition for all residents has been audited by the QA Nurse to check for notification of resident, physician, legal representative or interested family member.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Gudy Terry

Administrator

04/07/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to immediately inform the resident's primary caregiver when a change in the resident's condition occurred for one of three sampled residents. Resident #1 developed a Stage 1 pressure ulcer to the left lateral heel; however, there was no evidence the facility had notified resident #1's primary caregiver regarding the development of a pressure ulcer.</p> <p>The findings include:</p> <p>A review of the "Change in a Resident's Condition or Status Policy Statement" (no date) conducted on March 16, 2011, revealed the facility shall promptly notify the resident, his or her attending physician, and the representative (sponsors) of changes in the resident's condition and/or status.</p> <p>1. Resident #1 was admitted to the facility on January 9, 2011, and sent to the hospital on February 7, 2011. The facility discharged resident #1 on February 7, 2011, due to hospital admission.</p> <p>A review of the medical record revealed resident #1 was assessed by the weekly skin assessment nurse, Registered Nurse (RN) #4. Review of the weekly skin assessment tool dated February 1, 2011, completed by RN #4 revealed resident #1 was noted to have a red and slightly mushy left lateral heel. Further record review revealed RN #4 notified resident #1's physician regarding his/her findings of the skin assessment, however, there was no evidence the facility had informed</p>	F 157	<p>Systemic Changes</p> <p>RN #4 was educated on 4-11-2011 by the Director of Nursing on the proper notification of resident, physician and resident's legal representative or interested family member when there is a change in condition of the resident.</p> <p>All Charge Nurses were inserviced on 4-7-2011, 4-8-2011, 4-11-2011, 4-12-2011 by the Staff Development Director on the proper notification of resident, physician and resident's legal representative or interested family member when there is a change in condition of the resident.</p> <p>A change in condition for the resident is reviewed at the Daily Clinical Review (DCR) meeting Monday through Friday. At this time notifications are checked for resident, physician and resident's legal representative or interested family member when there is a change in condition of the resident.</p> <p>The QA Nurse is completing random audits of 10% of the residents weekly for proper notifications of change in condition.</p> <p>Monitoring</p> <p>The findings of the audits completed by the QA Nurse will be reviewed by the Quality Assurance Committee for follow-up and recommendations until compliance is achieved and, thereafter, sustained for three months.</p>		4-20-2011

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F 157	Continued From page 2 the resident's family when the pressure ulcer was identified. A review of the physician's orders for resident #1, dated February 1, 2011, revealed orders to apply selfa foam kerlix dressing to both heels for protection, and change the dressing every other day. An interview conducted with RN #4 on March 16, 2011, at 5:02 p.m., revealed a skin assessment was completed weekly on resident #1. RN #4 stated he/she completed a skin assessment on resident #1 on February 1, 2001, noting the resident's left lateral heel was red and mushy. RN #4 stated the area was considered a Stage 1 pressure ulcer. RN #4 stated he/she notified the physician, but did not notify resident #1's family/primary caregiver. An interview conducted with the Administrator on March 16, 2011, at 5:24 p.m., revealed the Administrator could not provide any evidence the facility had notified resident #1's primary caregiver regarding the development of a Stage 1 pressure ulcer identified on February 1, 2011, by RN #4.	F 157			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314	<u>F 314 D TREATMENT/SERVICES TO PREVENT/HEAL PRESSURE SORES</u> <i>Residents Found To Have Been Affected</i> Resident #2 is receiving interventions and treatments to include pressure sores per his care plan.		

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F 314	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide the necessary treatment and services to prevent the development of pressure sores for one of three sampled residents. Resident #2 was assessed to be at high risk for the development of pressure sores upon admission. However, the facility failed to develop/implement appropriate interventions and the resident developed an unstageable pressure sore eight days after admission.</p> <p>The findings include:</p> <p>A review of the facility's policy/procedure related to Pressure Sore Prevention (no date) revealed factors that placed a resident at risk for pressure sore development included significant changes in weight, mobility, edema, the requirement of protective skin care to areas other than the feet, and abnormal lab values. The policy noted the resident's skin should be assessed at least once per shift for any signs/symptoms of irritation or breakdown.</p> <p>A review of the medical record revealed resident #2 was admitted to the facility on March 7, 2011, with diagnoses that included Epilepsy, History of Noncompliance with medical treatment, Nondependent Alcohol Abuse, Monilial infection involving the inguinal area, and cognitive deficit.</p> <p>A review of the medical record revealed resident #2 had sustained a recent weight loss prior to admission to the facility. A review of the hospital discharge summary dated March 6, 2011,</p>	F 314	<p>Identification of Other Residents with the Potential to Be Affected The Quality Assurance Nurse and selected Charge Nurses have completed a review of each resident who have been assessed as a high risk for the development of pressure sores for Plan of Care, interventions and treatment and that the resident is receiving care accordingly. All residents who have been assessed as a high risk for the development of pressure sores have treatments and interventions in place to prevent pressure sores.</p> <p>Systemic Changes RN #4 was inserviced by the Director of Nursing on 4-11-2011 regarding identifying pressure sores, implementing interventions and treatments. And, assuring that this information is included and updated in the Comprehensive Care Plan and the SRNA Care Plan Record.</p> <p>All licensed nurses were inserviced by the Staff Development Director on 4-7-2011, 4-8-2011, 4-11-2011, 4-12-2011 regarding identifying pressure sores, implementing interventions and treatments. And, assuring that this information is included and updated in the Comprehensive Care Plan and the SRNA Care Plan Record.</p>		

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F 314	<p>Continued From page 4</p> <p>revealed resident #2's weight at the hospital was noted to be 180 pounds. Resident #2's weight at the facility was recorded as 160 pounds on March 7, 2011 and March 14, 2011. A review of the physician's orders revealed a Magic Cup and a speech therapy evaluation had been ordered to further evaluate the resident's nutritional needs/problems. A review of the laboratory tests conducted on March 8, 2011, revealed resident #2's total protein level was 6.4 g/dL (normal range is 6.4-8.2 g/dL) and the albumin was 2.7 g/dL (normal range is 3.4-5.0 g/dL).</p> <p>Further review of the medical record revealed a Braden Scale Pressure Sore Risk Assessment was completed upon admission to the facility for resident #2. The assessment revealed a total score of 14, which indicated the resident was at "high risk" for pressure sore development. However, there was no evidence the facility had developed an admission plan of care to include interventions to prevent pressure sore development for resident #2.</p> <p>A review of the admission nurse's notes dated March 7, 2011, at 12:45 p.m., revealed resident #2 was assessed to have a Stage 1 reddened area on the left buttock, blue discoloration on the right foot, a brown scabbed area on the top of the smallest toe of the left foot, and bilateral redness of the heels. A review of the weekly skin assessment conducted on March 8, 2011, revealed the Stage 1 area of the right buttocks was healed and the right heel remained slightly pink, but blanchable. However, there was still no evidence the facility implemented interventions to prevent breakdown of the resident's foot area. The weekly skin assessment conducted on March 15, 2011, identified the resident to have a</p>	F 314	<p>Certified nursing assistants were in serviced on 4-7-2011, 4-8-2011, 4-11-2011, 4-12-2011 by the Staff Development Director regarding pressure sore prevention.</p> <p>The initial Plan of Care that is developed upon admission is being reviewed at the Daily Clinical Review (DCR) meetings held Monday thru Friday to ensure that preventative measures are in place for those residents who are at high risk for pressure sores.</p> <p>The Quality Assurance Nurse and selected Charge Nurses are completing random audits of 10% of the residents weekly for who have been assessed as a high risk for the development of pressure sores for Plan of Care, interventions and treatment and that the resident is receiving care accordingly.</p> <p>Monitoring The findings of the audits completed by the QA Nurse will be reviewed by the Quality Assurance Committee for follow-up and recommendations until compliance is achieved and, thereafter, sustained for three months.</p>	4-20-2011	

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F 314	<p>Continued From page 5</p> <p>non-stageable 4-cm by 1-cm pressure sore of the left medial heel area. The wound was described as "dark, bluish discoloration; not mushy."</p> <p>A review of the physician's orders revealed the physician was contacted on March 15, 2011, for treatment orders for the left foot pressure sore. Orders were noted to apply telpha/foam/Kerlix dressing daily to the left foot wound until healed. In addition, orders were obtained to apply a heel boot to the left heel.</p> <p>Resident #2 was observed on March 16, 2011, at 1:10 p.m., to be sitting up in a recliner chair with both lower extremities slightly elevated. A dry dressing was observed on the resident's left foot. Resident #2 was not interviewable due to cognitive status. No heel protectors were observed to be in use.</p> <p>A skin assessment conducted with facility staff on March 16, 2011, at 2:45 p.m., revealed a reddened, blanchable area to the coccyx area. Heel protectors were observed to be in place on both of the resident's feet. Both lower extremities/feet were observed to have 2+ to 3+ pitting edema. An unstageable pressure sore was observed on the resident's left heel area, measuring approximately 3 cm by 1.5 cm. The wound was observed to be intact and reddened with a bluish discolored center. The resident was observed to require extensive assistance from staff with turning during the skin assessment.</p> <p>An interview conducted with LPN #1 on March 16, 2011, at 6:30 p.m., revealed LPN #1 had completed the admission skin assessment and the Braden Scale Pressure Sore Risk assessment for resident #2. LPN #1 stated if a</p>	F 314			

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F 314	<p>Continued From page 6</p> <p>resident was identified to be at risk for pressure sore development interventions were required to be implemented by the admission nurse. In addition, the LPN stated the staff person completing the admission skin assessment was also responsible to develop the admission care plan which should have included preventative interventions to reduce pressure sore development for resident #2. The LPN stated the admission care plan had not been completed due to the resident being admitted at the end of the shift and LPN #1 had asked the oncoming nurse to complete the care plan. LPN #1 also voiced directing the nurse aides to elevate resident #2's feet on a pillow until the redness resolved. LPN #1 stated she was not aware the resident had developed a pressure sore on the left heel.</p> <p>An interview conducted with RN #4 on March 16, 2011, at 4:35 p.m., revealed the RN was responsible to conduct weekly skin assessments for all residents in the facility. RN #4 stated she had contacted the resident's physician on March 8, 2011, regarding treatment orders for the inguinal/buttocks redness, but did not discuss the redness identified on the resident's heels. RN #4 stated there was no evidence the facility had implemented interventions to address the resident's heels until March 15, 2011, when the non-stageable pressure sore had been identified on the resident's left heel.</p> <p>An interview conducted with Certified Nurse Aide (CNA) #4 on March 16, 2011, at 7:00 p.m., revealed the CNA had not been directed to apply heel protectors or to use other interventions to resident #2's feet until March 15, 2011. CNA #4 stated she did not know why the heel protectors had been applied on March 15, 2011. CNA #4</p>	F 314			

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F 314	Continued From page 7 stated the heel protectors should be noted on the CNA care plan. However, a review of the CNA care plan revealed the interventions to address skin problems for resident #2 only included the application of a skin barrier. CNA #5 stated in an interview on March 16, 2011, at 7:10 p.m., that the CNA had never been instructed to use heel protectors or pillows to protect resident #2's feet from skin breakdown until March 16, 2011. CNA #5 also stated the heel protectors should be included on the CNA care plan.	F 314			